Bhalwani Familial Cancer Clinic (BFCC)
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Personal History Questionnaire

Last Name: _____ First Name: _____ Preferred Name: _____

Maiden Name: _____ Height: _____ Weight: _____

Sex assigned at birth: _____ Gender: _____ Preferred pronoun: _____

OHIP Health Card Number & Version Code: _____ Expiry Date: _____

Address: _____City: _____

Postal Code: _____ Tel (Home): _____ (Mobile): _____

Date of Birth: (Yy)_____/(Mm)_____/(Dd)_____ Occupation: _____

Highest education level attended: ☐Grade School ☐Secondary School ☐College ☐University

To help us forward appropriate letters and information to the doctors involved in your related medical care, please provide us with their full names and addresses. Please note that a letter will only be sent to these doctors if applicable or deemed appropriate by the clinic.

Family Physician: _____ Tel: _____

Address: _____

Specialist(s): _____ Tel: _____

Address: _____

Cancer History

If you have ever been diagnosed with cancer, please complete the following for each diagnosis. Please describe any chemotherapy, radiation, or surgery you had for treatment:

Type of cancer: _____ Age when diagnosed: _____

Year of diagnosis: _____ Hospital(s) where treated: _____

Treatment received: _____

Type of cancer: _____ Age when diagnosed: _____

Year of diagnosis: _____ Hospital(s) where treated: _____

Treatment received: _____

Medical History

1) Do you have any **chronic** medical conditions eg. heart disease, diabetes? ☐No ☐Yes

If yes, please describe: _____

_____

_____

2) Are you currently on any **medication**? ☐No ☐Yes

Type: _____ Reason: _____ for total of _____ years

Type: _____ Reason: _____ for total of _____ years

Type: _____ Reason: _____ for total of _____ years

3) Have you ever had **surgery or a bone marrow transplant**? ☐No ☐Yes

If yes, please provide details: _____

_____

4) Have you ever had a **breast biopsy**? ☐No ☐Yes

If yes, indicate the number of biopsies, date, and result, or provide a copy of the report:

_____

5) Have you ever had **colon cancer** screening? Fecal Occult Blood Test ☐No ☐Yes

Colonoscopy ☐No ☐Yes

If yes, please indicate the result and the year of your most recent screening: _____

_____

6) Have you ever taken hormones (eg. for menopause, gender affirmation)? ☐No ☐Yes

If yes, please describe: _____

_____

Family History

7) Have you or anyone in your family ever been diagnosed with a **genetic condition** such as Cystic fibrosis or Down syndrome? ☐No ☐Yes ☐Don't know

If yes, please describe: _____

8) Have you or anyone in your family ever had **genetic testing** for hereditary cancer? ☐No ☐Yes ☐Don't know

If yes, provide their name, hospital at which they were tested and results if known: _____

_____

Gynecological & Reproductive History (if applicable)

9) Age at which you **started** menstruating (having periods): _____

10) Have you **stopped** menstruating? ☐No ☐Yes Age: _____

If yes, what was reason? ☐ Menopause ☐ Surgery ☐ Chemotherapy ☐ Other: _____

11) How many times have you been **pregnant** in total? _____

What was the outcome of all of your pregnancies? Live born children: _____ Abortions: _____

Miscarriages: _____ Stillbirths: _____

Signature: _____ Date: _____